THE OFFICE OF THE INSPECTOR GENERAL FOR MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES

PRIMARY INSPECTION
Virginia Center for Behavioral Rehabilitation

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Inspector General

OIG REPORT # 99-04

EXECUTIVE SUMMARY

The Office of the Inspector General conducted a primary inspection of the Virginia Center for Behavioral Rehabilitation (VCBR) on July 13 and July 16, 2004. Review activities included interviews with administrative, clinical, and direct care staff, as well as staff in the Department of Mental Health, Mental Retardation and Substance Abuse Services' (DMHMRSAS) Central Office. Residents were also interviewed. A tour of the facility was conducted including the observation of active treatment programming. Documentation reviews included: resident records, approved policies and procedures, and training schedules.

Primary inspections are defined as routine comprehensive reviews of quality indicators such as the provision of active treatment within the context of the total environment of care. This includes but is not limited to the availability of adequate staff, the assurance of human rights, and the residents' access to medical care. The purpose of this type of inspection is to evaluate specific components of quality care as delivered by the facility and to make recommendations regarding performance improvement. The report is intended to provide a view into the current functioning of this program of behavioral rehabilitation for persons under civil commitment as sexually violent predators (SVP).

VCBR is the maximum-security residential treatment program operated by DMHMRSAS in response to the VA code provision that allows for the civil commitment of persons determined to be sexually violent predators. The facility is temporarily located in Petersburg on the Southside Virginia Training Center (SVTC) Campus. This facility became operational in July 2003. The first admission occurred in December 2003.

The facility is currently addressing issues associated with meeting the challenge of developing and implementing an integrated treatment program while simultaneously focusing on issues relevant to making the facility operational, such as hiring adequate staff, drafting and approving policies and procedures, and implementing human rights regulations. DMHMRSAS and facility management are to be commended for securing the physical plant and accomplishing other tasks associated with opening a new facility in such a short period of time. This report provides recommendations regarding priority areas where continued efforts are needed.

Facility:	Virginia Center for Behavioral Rehabilitation Petersburg, Virginia
Date:	July 13 and July 16, 2004
Type of Inspection:	Primary Inspection / Unannounced
Reviewers:	James W. Stewart, III Cathy Hill, LPC

Sources of Information: Interviews were conducted with administrative, clinical, and direct-care staff, as well as staff in DMHMRSAS Central Office. Residents were also interviewed. Documentation reviews included, but were not limited to: resident records, selected Policies and Procedures, and facility training materials. A tour of the residential and treatment areas was conducted. Activities and staff/resident interactions were observed.

Areas Reviewed:	Section One /Treatment Environment Section Two / Active Treatment Program Section Three /Access to Medical Care Section Four / Application of Human Rights Section Five/ Use of Seclusion and Restraint

Introduction:
Virginia has joined a number of states in enacting legislation that allows for the civil commitment of persons found to be sexually violent predators upon completion of their mandatory prison sentence. The Supreme Court declared (Kansas vs. Hendricks) that the civil commitment of sexually violent predators is constitutional.

The Civil Commitment of Sexually Violent Predators (§ 37.1-70.10.) outlines the following:

> *Any person committed pursuant to this article shall be placed in the custody of the Department of Mental Health, Mental Retardation and Substance Abuse Services for control, care and treatment until such time as the person's mental abnormality or personality disorder has so changed that the person will not present an undue risk to public safety. The Department of Mental Health, Mental Retardation and Substance Abuse Services shall provide such control, care and treatment at a facility operated by it, or may contract with private or public entities, within or without the Commonwealth, and with other states to provide comparable control, care or treatment. At all times, persons committed for control, care and treatment by the Department of Mental Health, Mental Retardation and Substance Abuse Services pursuant to this article shall be kept in a secure facility. Persons committed under*

this article shall be segregated by sight and sound at all times from prisoners in the custody of a correctional facility. The Commissioner may make treatment and management decisions regarding committed persons in his custody without obtaining prior approval of or review by the committing court.

The Civil Commitment of Sexually Violent Predators Act became effective April 2, 2003. One provision of this act establishes the Department of Corrections' Commitment Review Committee (CRC). It is the responsibility of this committee to screen and evaluate prisoners that have been convicted of a sexually violent offense and scored 4 or more on the RRASER prior to their mandatory release date. The CRC recommends if the person should be released, be conditionally released, or civilly committed as a sexually violent predator.

It is only through defined legal processes that a court can determine that a person, through clear and convincing evidence, requires civil commitment. Once commitment occurs the person is placed in the custody of the DMHMRSAS.

Persons committed as sexually violent predators to the custody of DMHMRSAS are admitted to VCBR. Interviews with administrative and treatment staff defined the mission of the facility to be two fold: assuring public safety and the provision of treatment. One of the challenges for this facility is that it does not clearly fit the definitions traditionally associated with either a correctional facility or a mental health facility but it must meet many of the expectations required of both systems.

VCBR is the maximum-security residential treatment program operated by DMHMRSAS for individuals civilly committed as sexually violent predators (SVP). The facility, which became operational in July 2003, is temporarily located in Petersburg on the Southside Virginia Training Center (SVTC) Campus. It has been projected that the facility will be maintained at this temporary site for a period of no greater than three years. The facility has an initial operating budget of 5.8 million dollars over the next two years. Interviews revealed that the estimated annual cost per bed is $80,000 at this temporary site. The projected annual cost per bed once the facility is in its permanent location is around $68,000.

The main facility consists of two residential buildings. Because of space limitations, administrative offices are housed in a separate building outside the secured compound. Conversion of this site to a maximum-security facility began in April 2003 with the addition of perimeter fencing, razor wiring and motion detectors around the two primary residential and treatment buildings. The buildings were renovated to include increased security measures such as closed circuit cameras in the common areas, magnetic doors, steel mesh wire and shatterproof windows. Each building contains two residential treatment areas consisting of a day room, staff offices and/or treatment areas, a communal bathroom and shower area, nine bedrooms and a seclusion/restraint room.

The current arrangement of bedrooms can house 36 residents, if each resident is assigned to a single room. While the facility could house 72 residents if all the residents were double bunked, interviews with administration revealed that the maximum operating capacity has been determined to be 48 residents. This allows for 12 person residential units with the current configuration of designated programming space. The designation of 12 persons per unit will require double bunking of several residents. This will only occur after all clinical and security considerations have been thoroughly examined.

To house more than 12 residents within the current unit design would severely restrict available program space limiting its effectiveness. The alternative would be to create additional treatment space within the fenced area through new construction or the purchase of temporary prefabricated units.

The first admission to the facility occurred in December 2003. The census on the day of the inspection was nine residents. It is projected that the tenth resident could enter the facility within the next 14 to 60 days. At that time, the management team will decide whether to place that person in the currently occupied residential unit or open the next unit.

It has been projected that the program will receive approximately 2 admissions per month through 2008. If the projected admission rates are correct the program in its current location, will have 21 residents by January 2005, and be at the previously identified maximum operating capacity by February 2006.

SECTION ONE / TREATMENT ENVIORNMENT

Finding 1.1: The residential areas were clean and well maintained.

A tour was conducted of the one opened residential unit. The living areas were clean and well maintained. The furniture was adequate to meet the needs of the residents. Each bedroom contained a bed, wardrobe, desk and chair. Residents have the opportunity to retain personal items in their rooms as long as the items have been approved and do not present a security risk. Communal bathrooms were designed to afford the residents some privacy.

A telephone designated for residents' usage was on the living unit. Smoking is permitted in designated outside areas and at designated times. Smoking occurs under staff supervision. Residents have access to approved recreational areas. Behind the residential area is a basketball court.

DMHMRSAS in conjunction with the Department of Corrections (DOC) did a nice job in converting this facility into its current usage as temporary quarters for this program.

Recommendation: Given the temporary status of this facility, the OIG does not have any specific recommendations at this time.

Finding 1.2: The facility design and security procedures are adequate to assure a secure environment for the projected maximum census. Security staffing is adequate for the current census but will need to be expanded to accommodate the full census at this site.

The process of recruiting and retaining qualified personnel for this program has been challenging. Interviews with administrative staff indicated that in its current location, the facility is competing with three other state operated facilities and a federal prison in its efforts to hire sufficient numbers of qualified direct care staff. This does not include the added market competition that exists with private providers and/or private industry.

In addition to the issues associated with a competitive market, it is often difficult to find qualified individuals who have chosen to work with this challenging population. The facility has experienced some turnover in staff but this has been limited. The turnover is not unexpected as both facility management and staff are in the process of determining the best "fit" for this population.

The first complement of staff hired for this facility was security personnel, many of whom were hired in July 2003. Senior security personnel, in conjunction with DMHMRSAS Central Office staff, initially focused on assessing security risks and establishing security protocols, including the preliminary training of residential unit security staff. Interviews with management and security staff indicated that security protocols were well established prior to the admission of the facility's first residents. The facility Operations Manager provides supervision of the security staff and has been actively reviewing and adapting the current practice protocols into facility policy and procedures.

Recommendation: None.

SECTION TWO / ACTIVE TREATMENT

Finding 2.1: The facility has adopted a model of treatment widely used with this specially defined population. The model employs a cognitive-behavioral and relapse prevention approach to treatment.

A review of program offerings, interviews with staff and residents, and observations of a group session revealed that the facility has initiated a program of the structured treatment. The treatment program, which is grounded in cognitive-behavioral treatment approaches, consists of five phases. Each phase is consistent with a corresponding number of overall program treatment goals. Advancement to the next phase of treatment is dependent on each resident's progress with the prescribed treatment goals for each stage. Resident are not required to participate in the treatment process but are reminded that reintegration into the community is contingent upon their successful completion of the program.

The phases, as currently identified, are as follows:

- Phase I focuses on the individual's acknowledgment of his behavior and its impact both on his life and that of his victims. This phase also consists of the completion of a comprehensive assessment and evaluation for the purpose of identifying short-term treatment objectives through the formulation of a treatment plan. Residents are encouraged to actively participate in the development of their treatment plan.
- Phase II assists the residents in developing the motivation necessary for engaging in increasingly in-depth self-examination regarding each person's pattern of sexually abusing others and the associated distorted thought patterns. Residents gain insight regarding their personal patterns of sexual arousal, aggression and cycle of offending. Residents will begin the process of interrupting their patterns of offending through self-disclosure and peer feedback.
- Phase III focuses on skills acquisition, application and integration. Residents will become increasingly aware of their personal areas of high risk and learn techniques for either staying out of or dealing with these situations. Anger management, progressive relaxation techniques, stress reduction and appropriate social interactions will be emphasized during this phase. Residents in this phase are expected to act as appropriate role models and provide leadership on their living units.
- Phase IV practices skills generalization through increased opportunities to demonstrate both behavioral and attitudinal changes. There will be increased opportunities for the residents to interact with their natural support systems during this phase of treatment. Residents are clearly expected in this phase to demonstrate treatment concepts through more pronounced behavioral control.
- Phase V represents discharge readiness and transition into the community. Relapse prevention plans, a consistent demonstration of behavioral control, and the successful development of effective coping strategies must be evident. The resident's ability to effectively demonstrate these skills will result in the forwarding of a petition for conditional release to a less restrictive environment to the court of jurisdiction for review. This summary enables the individual to be considered for transition to a less restrictive environment.

The program designed for use at this facility is consistent with the model widely used in other states providing for the treatment of sexually violent predators in similar secure settings. DMHMRSAS Central Office staff consulted with several leading experts in this field of treatment throughout the development of this model.

Interviews with clinical management staff indicated that the facility is reviewing the possibility of developing a pretreatment phase for those persons not motivated to participate in active treatment. This phase will focus on assisting the resident in acclimating to the facility and providing adequate structure and support so as to diminish disruptive or maladaptive behaviors while fostering appropriate responses within the setting and motivating the resident to become actively engaged in treatment.

The facility has designed a program of active treatment, which includes scheduled treatment sessions held throughout the day.

Recommendation: None.

Finding 2.2: Current staffing for treatment activities is not adequate to provide a full program of active treatment for the current residents. Recruitment is underway to fill treatment positions.

The program design includes engaging residents in active treatment programming activities throughout the day. Sessions are divided into morning and afternoon activities. During the tour of the facility, a member of the OIG review team observed a morning treatment session. Seven of the nine residents were present. Six of these were attentive, if not actively participating in the group discussion. Only one person was not at all engaged. Even though he was not engaged, the person was not disruptive to the process. The session was held in a space surrounded by tall dividers that did not reach the ceiling. A single security officer was posted on the opposite side of the divider, out of view however, the officer was able to hear the discussion. The issue of confidentiality was raised as a concern during interviews with residents. The ability of security officers to hear residents' disclosures is disconcerting for some persons still acclimating to the facility.

In the session that was observed, the therapist actively engaged the participants in a therapeutic discussion of their deviant behavioral history. The therapist was respectful, appropriately active, and was able to keep the discussion on track.

Interviews and observations revealed that afternoon therapeutic activities are provided on a limited basis. The residents reported that during the afternoon sessions they are, for the most part, not actively engaged in treatment. Several residents have identified this as a concern to the human rights advocate. Observation of afternoon activities during the facility tour noted one resident playing a video game, two residents playing a card game with each other, two others playing solitaire, and one resident just sitting. One resident appeared to be writing a letter. Two staff members were present but neither was engaged in activities with the residents.

The team was informed that the facility had recently hired a recreation therapist, whose primary responsibility will be to develop and initiate afternoon therapeutic activities that are consistent with the individualized treatment goals of each resident. It was anticipated that this person would begin employment in the next two weeks. Nursing staff will also provide educational groups on topics such as nutrition, health management and other related topics as increased staff are hired to support these activities.

Administrative staff reported that the facility plans to offer a variety of programming options during the evenings and weekends as well. Included are activities designed for identifying and increasing leisure skills, such as arts and crafts and recreational activities. Educational opportunities will also be provided. Other offerings will include anger management, relaxation techniques, stress management classes, and current events discussions. Implementation of these activities is contingent upon the addition of qualified staff.

The facility director was hired in October 2003. One of his primary tasks has been the recruitment of staff. In addition to the management for operations and support personnel, the staffing for treatment at current and capacity levels for this facility are as follows:

	Number of Staff Currently	**Number of Staff at Capacity**
Clinical		
Clinical Director (PhD)	Hired (12/03)	1
Psychologists II	1	2
Rec. Therapists	1	2
Social Workers (MSW)	1	4
Direct Care Associates	2	20
Educational Instructors	0	2
Medical		
Primary Care Physician	1 (FT)	1
Nursing	3	7
Consulting Psychiatrist	1 (PT)	1

Recommendation: Take additional steps that will enable implementation of the full treatment program quickly. If recruitment for permanent staff will not be completed in a reasonable period of time, identify and implement alternative methods to engage treatment staff, such as contracting with hourly professional staff on a temporary basis.

DMHMRSAS Response:
VCBR has filled two of the most critical clinical positions. A licensed clinical social worker and recreation therapist began work on August 10, 2004. On September 7, 2004, the facility implemented a new treatment schedule that provides an additional twelve hours of structured treatment activities per week, bringing the total of treatment activities provided to eighteen hours per week. We are also providing educational services for 60-90 minutes per week. We believe this is comparable to other SVP facilities .VCBR continues to recruit for another social worker and unit psychologist. The facility anticipates filling these positions by January 1, 2005.

SECTION THREE / ACCESS TO MEDICAL CARE

Finding 3.1: The system developed for providing medical care is adequate to address both the acute and chronic care needs of the residents. Nursing staff will need to be expanded as census increases and nursing responsibilities for participation in active treatment programming are initiated.

VCBR has a full-time primary care physician. The physician is on-site Monday through Friday during the day shift and on-call after hours, including holidays and weekends. The facility has made arrangements to contract with a local practice to provide coverage when the primary physician is on vacation. In addition, the facility has contracted with a consulting psychiatrist to provide services as needed.

On-site plans of care are managed by nursing personnel. The facility currently has three full-time nurses, plus a nurse administrator. Agency nurses are used to supplement any absences of the current employees. The nurses conduct the residents' initial assessment. Vital signs are taken daily during the first three days following admission and monthly after the completion of this initial physical assessment period.

All residents undergo a complete physical examination by the physician within twenty-four hours of their admission. Acute and/or chronic medical problems identified are noted on the patient's treatment plan. Nursing staff documents the course of treatment on care plans and manage the day-to-day interventions outlined on the plans. It is the responsibility of nursing personnel to communicate to the appropriate authority any medical concerns that could have an impact on a resident's ability to function within the treatment program or which may present security concerns.

The facility uses a sick-call system for the provision of non-emergency medical care. Residents are asked to complete a form outlining their chief medical complaints. The form is then forwarded to the nurse on duty for review. The nurse makes the arrangements for the residents to be seen. Specialized care is provided in the community through the use of consultants or, as appropriate, at Hiram W. Davis Medical Center. Security personnel are assigned to accompany the resident to off campus outpatient appointments and special hospitalizations.

Recommendation: None.

SECTION FOUR / APPLICATION OF HUMAN RIGHTS

Finding 4.1: An advocate has been assigned to the facility. The advocate is actively involved in providing oversight and consultation to this program through training, contact with residents and staff, and the monitoring of program development relevant to human rights concerns. Residents and staff understand how to contact the advocate.

The advocate who has primary responsibility for Piedmont Geriatric Hospital has been assigned as advocate for VCBR. The advocate participates in many information-sharing forums with administrative staff in order to keep abreast of issues that may be relevant to human rights, particularly as this program progresses. She has provided consultation to administrative staff regarding the development of policies and procedures and the resident handbook. She conducts staff human rights orientation and training. Interviews with staff describe a good working relationship with the advocate.

The advocate meets with residents to review their rights. She also meets regularly with residents in response to identified concerns or complaints. All four of the patients interviewed were able to identify the advocate and how to get in touch with her. A poster providing contact information was located on the wall in the residential day room area.

The States Human Rights Committee (SHRC) will serve in lieu of a local human rights committee for this facility. This decision was reached after careful consideration and in order to provide this population with a complaint process that is more structured and requires less time to complete. The committee will hear appeals on behalf of the residents regarding any unresolved complaints or concerns relevant to the human rights regulations.

Recommendation: None.

Finding 4.2: VCBR is operating without established policies and procedures in a number of areas that govern facility operations, including critical policies that govern practices for exemptions to the human rights regulations.

The DMHMRSAS Human Rights Regulations state that the regulations apply to individuals "committed to the custody of the commissioner as sexually violent predators, except to the extent that the commissioner may determine these regulations are not applicable to them." The regulations also provide guidance regarding the process by which the Commissioner may notify the SHRC chairperson of any exceptions to the

regulations. Notification of the exemptions occurred in October 2003. These exemptions are scheduled to be reviewed again in October 2004.

To date the facility has not finalized the policy and procedures manual governing its operations. This is particularly critical for the policies and procedures that govern patients' rights such as residents access to mail, telephone usage, visitation, the use of seclusion and restraint, and segregation for which exemptions were authorized by the Commissioner in October 2003.

The Policies, which have been approved include:

- Medical Assessments
- Special Hospitalizations and Off Campus Health Services
- Emergency Medical Responses
- Abuse and Neglect Reporting and Investigations
- Resident Fund Accounts
- Searches of Persons and Property
- Staff Transportation of Residents

Interviews indicated that a number of policies have been drafted but have been delayed due to the review process, which includes the rerouting of drafted policies once comments are integrated. It was reported that this process has taken ninety days or longer for a single policy to be completed.

Interviews revealed that the responsibility for drafting the policies has changed hands several times since the program began operations. Members of the Central Office's Office of Health and Quality Management were initially involved in drafting the policies and procedures. It was reported that responsibility for completing this task was transferred to the facility just prior to this inspection. Facility administration has established a committee for the purpose of completing this task. The facility projects that the policy and procedures manual will be completed no later than December 2004. Interviews revealed that this facility's unique status within the mental health, mental retardation and substance abuse service delivery system has made the development of policies and procedures more challenging because there are not established standards of care that can be used as a foundation for their development.

The completion of the policy and procedures manual is a critical task for this facility. Practices are being established because of the need to provide structure and consistency within the treatment environment that may not reflect the actual policy once it is finalized. This has the potential of creating confusion for both the staff and residents. The longer it takes to formulate and approve policies, the greater the risk that current practice will become the "institutionalized" standard of care.

Recommendation: Streamline the process for drafting and approving policies and procedures in order to complete this task as quickly as possible.

DMHMRSAS Response:
DMHMRSAS acknowledges that the process for new policy development at VCBR has been particularly cumbersome as is often the case with a new unit and with the need in this case of close collaboration with the Office of the Attorney General. A primary consideration in the development of policies at VCBR has been preventing misinterpretation and contradiction with DMHMRSAS Departmental Instructions, Human Rights regulations and the Code of Virginia. VCBR has hired an employee whose primary duties include drafting and organizing policy development. The facility has also designated appropriate employees to develop and revise policies relevant to their departments. The facility is holding weekly meetings to update the status of policies in progress. We expect to have all policies with Human Rights implications completed by January 1, 2005. The policy development team meets weekly to review policy status and to assign policy development to specific staff members who are responsible for enacting and enforcing those policies. The SHRC advocate, Anne Stiles, meets regularly with the policy development team and keeps in touch by email nearly daily.

Finding 4.3: Staff have a working knowledge of issues associated with abuse and neglect.

The staff members interviewed had a working knowledge of the policy and procedures associated with identifying and reporting abuse and neglect. All were able to appropriately identify the reporting process as outlined by the facility policy. All described the importance of staff treating the residents with dignity and respect. The majority indicated that it was the responsibility of staff to model appropriate social interaction with the residents and to monitor interactions so as to prevent situations that could result in neglect or abuse.

All the residents interviewed indicated that the interactions between staff and residents are generally positive. Staff were described as courteous, friendly and respectful.

Recommendation: None.

SECTION FIVE / USE OF SECLUSION AND RESTRAINT

Finding 5.1: The use of seclusion and restraint is governed by the provisions outlined in the DMHMRSAS Human Rights regulations except for the exemptions issued on October 31, 2003.

Residents are provided a copy of the Resident's Handbook following admission to the facility. The handbook outlines the program's rules of conduct. Residents are provided an orientation to the handbook including being notified of the range of consequences associated with displays of physical violence within the setting.

Seclusion and restraint are restrictive procedures utilized in Virginia under clearly prescribed emergency situations when there is an imminent risk of harm to the consumer or others, and only in the event of failure of other interventions. Staff at the facility have received training in therapeutic interventions that are designed to de-escalate the types of behaviors that might lead to emergency situations.

The following exemptions to the human rights regulations have been authorized for this facility:

- The facility is permitted to use restraints as a security measure during the transport of residents beyond the secure perimeter.
- The facility is permitted to extend the time limit for an authorization for seclusion.
- The facility is permitted to use administrative isolation.

Segregation or isolation is a technique utilized in correctional facilities for the purpose of maintaining control over potentially escalating risk factors/behaviors that may impact facility safety. Administrative staff reports that the use of isolation in this facility will be defined by policy and procedures.

The facility has not implemented the use of these restrictive procedures in the absence of an approved policy. When a situation arises that can not be handled through therapeutic interventions, the facility utilizes the services of local law enforcement because they have clearly established guidelines for actions designed to decrease the risks to the public and for containment of an emergency situation.

Recommendation: Prioritize the completion of the policies and procedures governing the use of restrictive procedures and practices associated with the exemptions in order to assure residents rights and provide staff with clear guidelines for handling emergency and other situations.

DMHMRSAS Response:
The Department recognizes the need to prioritize policies and procedures involving safety, security and human rights. VCBR has written and submitted policies regarding seclusion and restraint, separation and other policies involving human rights to the Attorney General's Office as well as the State Human Rights Committee (SHRC). The SHRC has approved the Seclusion and Restraint policy and the Separation Policy at this time. These policies are being followed at VCBR.